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CHAPTER TWENTY-THREE

HOSPITAL REIMBURSEMENT PROGRAM

Chapter 23 Hospital Reimbursement Program.

Rule No. 560-X-23-.01 Introduction

(1) This Chapter of the Alabama Medicaid Administrative Code has been promulgated by the Alabama Medicaid Agency (Medicaid) as a guide for providers of Medicaid hospital care. This Chapter is applicable to all hospitals participating in the Alabama Medicaid Program.

Author: Keith Boswell, Director, Provider Audit/Reimbursement.
Statutory Authority: State Plan, Title XIX, Social Security Act, 42 C.F.R. Section 401, et seq.
History: Effective June 9, 1986. **Amended**: February 9, 1988. **Amended**: Emergency Rule filed and effective September 2, 1010. **Amended**: Filed September 20, 2010; effective December 17, 2010.

Rule No. 560-X-23-.02 Definitions and Basic Concepts

(1) Access Payment: A payment by the Medicaid program to an eligible hospital for inpatient and outpatient hospital care provided to a Medicaid recipient. The access payment will be made contingent upon the assessment tax required by Ala. Code (1975) §40-26B-70, et seq. being collected.

(2) Hospital: For purposes of Medicaid base, access and DSH payments for the period from October 1, 2009, through September 30, 2011, a facility, which is licensed as a hospital under the laws of the State of Alabama, provides 24-hour nursing services, and is primarily engaged in providing, by or under the supervision of doctors of medicine or osteopathy, inpatient services for the diagnosis, treatment, and care or rehabilitation of persons who are sick, injured, or disabled.

(3) Medicare Cost Report: The electronic cost report (ECR) filing of the CMS Form 2552-96 Hospital and Hospital Health Care Complex Cost Report, as defined in CMS Provider Reimbursement Manual (PRM) 15-II (hereinafter referred to as "Form CMS 2552-96) and all accompanying schedules, forms and supporting information.

(4) Privately Owned and Operated Hospital: For purposes of Medicaid base, access and DSH payments for the period from October 1, 2009, through September 30, 2011, a hospital in Alabama other than:

(a) Any hospital that is owned and operated by the federal government;

(b) A hospital that is a state agency or unit of state government, including without limitation a hospital owned by a state agency or a state university.

(c) A hospital created and operating under the authority of a governmental unit which has been established as a public corporation pursuant to Chapter 21 of Title 22 or Chapter 95 of Title 11, or a hospital otherwise owned and operated by a unit of local government.

(d) A hospital that limits services to patients primarily to rehabilitation services as authorized by Alabama Administrative Code 410-2-4-.08; or

(e) A hospital granted a Certificate of Need as a Long Term Acute Care Hospital as defined by Alabama Administrative Code 410-2-4-.02(8).

(5) Non State Government Owned and Operated Hospital: For purposes of Medicaid base, access and DSH payments for the period from October 1, 2009, through September 30, 2011, a hospital in Alabama created or operating under the authority of a governmental unit which has been established as a public corporation pursuant to Ala. Code, Chapter 21 of Title 22 or Chapter 95 of Title 11, or a hospital otherwise owned or operated by a unit of local government.

(6) State Owned or Operated Hospital: For purposes of Medicaid base, access and DSH payments for the period from October 1, 2009, through September 30, 2011, a hospital in Alabama that is a state agency or unit of state government, including without limitation a hospital owned or operated by a state agency or a state university.

Author: Keith Boswell, Director, Provider Audit/Reimbursement.
Statutory Authority: State Plan, Title XIX, Social Security Act, 42 C.F.R. Section 401, et seq.
History: Effective June 9, 1986. **Amended**: October 11, 1986; September 9, 1987; May 25, 1988; November 10, 1988; April 14, 1989. **Amended**: Emergency Rule effective October 1, 1991. **Amended**: January 14, 1992; September 11, 1992, May 13, 1993, January 11, 1996. **Amended**: Emergency Rule filed and effective September 2, 1010. **Amended:** Filed September 20, 2010; effective December 17, 2010.

Rule No. 560-X-23-.03 Inpatient Medicaid Base Payment

(1) For the period October 1, 2009, through September 30, 2011, each hospital shall receive an inpatient Medicaid base (per diem) payment, in accordance with the following:

(a) Medicaid shall pay each hospital as a base (per diem) amount for state fiscal years 2010 and 2011 the total inpatient payments made by Medicaid to each hospital from all sources except DSH payments during state fiscal year 2007, divided by the total paid inpatient hospital days incurred by that hospital in state fiscal year 2007, multiplied by the inpatient hospital days incurred by each hospital during fiscal years 2010 and 2011.

(b) Base (per diem) payments for state fiscal years 2010 and 2011 will not be made to any non state government owned or operated hospital, state owned or operated or privately owned or operated hospital that was in operation during the hospital's fiscal year ending in 2007 that ceases to operate as a hospital, beginning on the date that the facility ceases to operate as a hospital.

(c) Base (per diem) payments will be interim payments for hospitals that qualify for and file Certified Public Expenditures.

(d) Base (per diem) payments will be reviewed on a quarterly basis to ensure that hospitals are not paid more than the sixteen day reimbursement limit, per beneficiary, except for children under the age of one, or under the age of six who are receiving medically necessary inpatient services in a hospital which has been designated by Medicaid as a disproportionate share hospital, or who have been referred for treatment as the result of an EPSDT screening. Adjustments will be made to hospitals' interim payments to reflect the results of the reconciliation. Hospitals which are privately owned or

operated will be reimbursed on the basis of a maximum sixteen day annual beneficiary limit, subject to a maximum reimbursement equivalent to the current per diem amount multiplied times the covered days (limited to the 16 day annual beneficiary limit).

Author: Keith Boswell, Director, Provider Audit/Reimbursement.
Statutory Authority: State Plan, Title XIX, Social Security Act, 42 C.F.R. Section 401, et seq.
History: Effective June 9, 1986. **Amended**: November 10, 1986; August 10, 1987; May 25, 1988, July 12, 1988; May 12, 1989. **Amended**: Emergency Rule effective June 20, 1989. **Amended**: September 13, 1989. **Amended**: Emergency Rule filed and effective September 2, 2010. **Amended**: Filed September 20, 2010; effective December 17, 2010.

Rule No. 560-X-23-.04 Inpatient Hospital Access Payments

(1) For the period October 1, 2009, through September 30, 2011, the amount available for inpatient hospital access payments shall be calculated as follows:

(a) The state shall annually identify the total Medicaid inpatient hospital payments for privately operated hospitals for state fiscal year 2007 from all sources except DSH payments.

(b) The state shall estimate the amount that would have been paid for the services identified in step (1) using Medicare principles consistent with the upper payment limit (UPL) requirements set forth in 42 CFR 447.272.

(c) The state shall subtract step (a) from step (b) to determine the aggregate inpatient hospital access payment amount.

(2) For the period October 1, 2009, through September 30, 2011, in addition to any other funds paid to hospitals for inpatient hospital services to Medicaid patients, each eligible private hospital, excluding free-standing psychiatric hospitals, shall receive inpatient hospital access payments each state fiscal year. Inpatient hospital access payments shall include the following:

(a) An inpatient hospital access payments equal to 121 percent of the difference between the hospital's allowable cost of providing Medicaid inpatient hospital services for state fiscal year 2007 and base payments for the current fiscal year. The access payment will be made contingent upon the assessment tax required by Ala. Code (1975) §40-26B-70, et seq.being collected.

(b) A payment for private hospitals that do not qualify for disproportionate share payments, calculated as follows:

(1) For hospitals with uninsured uncompensated care costs greater than $800,000 in state fiscal year 2007, a payment equal to $400 per Medicaid inpatient day.

(2) For hospitals with uninsured uncompensated care costs less than $800,000 in state fiscal year 2007, a payment equal to $100 per Medicaid inpatient day.

(c) These additional inpatient hospital access payments shall be made on a quarterly basis.

(d) When combined with base payments, inpatient hospital access payments shall not exceed the annual inpatient upper payment limit.

Author: Keith Boswell, Director, Provider Audit/Reimbursement.
Statutory Authority: State Plan, Title XIX, Social Security Act, 42 C.F.R. Section 401, et seq.
History: Effective June 9, 1986. **Amended**: Emergency Rule filed and effective September 2, 1010. **Amended**: Filed September 20, 2010; effective December 17, 2010.

Rule No. 560-X-23-.05 Psychiatric Hospitals

(1) For the period October 1, 2009, through September 30, 2011, in addition to any other funds paid to private free-standing psychiatric hospitals for inpatient hospital services to Medicaid patients, qualifying hospitals shall receive an annual private free-standing psychiatric hospital access payment equal to ~~$185 per~~ Medicaid inpatient day paid in state fiscal year 2007.

(2) For the period October 1, 2009, through September 30, 2011, Medicaid shall pay Bryce Hospital Adolescent Unit a base (per diem) payment based on 2007 inpatient payments divided by 2007 total Medicaid days trended by the hospital market basket index as published by Global Insight Health-Care Cost Review to the current fiscal year.

(3) General - Annual cost report filing, by completing Medicaid prescribed standard cost report forms, is mandatory for ~~P~~psychiatric hospitals. Cost reports shall be completed in accordance with the Instructions for the Alabama Medicaid Uniform Cost Report.

(a) Cost Report Year-Ends - Each provider is required to file a uniform cost report for each fiscal year. The provider may elect the last day of any month as the fiscal year end. The cost report is due ninety (90) days after the fiscal year end elected by the provider. To change the fiscal year end, a written request must be received by the Alabama Medicaid Agency no later than sixty (60) days prior to the close of the provider's current cost reporting period. Providers must have written approval from the Alabama Medicaid Agency before changing the reporting period.

(b) Cost Report Filing - One copy of the complete uniform cost report must be received by Medicaid within three months after the Medicaid cost report year-end. It shall be signed by an authorized official or owner of the hospital. If the cost report is prepared by anyone other than an official or a full-time employee of the hospital, such person shall duly execute and submit the report as the Cost Report Preparer. The signatures of both the hospital official and Cost Report Preparer, if any, must be preceded by the following certification:

INTENTIONAL MISREPRESENTATION OR FALSIFICATION OF
ANY INFORMATION CONTAINED IN THIS COST REPORT MAY
BE PUNISHABLE BY FINE AND/OR IMPRISONMENT UNDER
FEDERAL LAW.

I HEREBY CERTIFY that I have read the above statement and
that I have examined the accompanying
Cost Report and supporting schedules prepared

on behalf of(hospital name(s) and Number(s)) for the cost report period beginning and ending and that to the best of my knowledge and belief, it is a true, correct, and complete report prepared from the books and records of the hospital(s) in accordance with applicable Alabama Medicaid Reimbursement Principles, except as noted.

Signed _____
Officer or Administrator
of Hospital(s)

Cost Report Preparer

By:

Title

Date

Date

Any cost report received by Medicaid without the required original signatures and/or certification(s) will be deemed incomplete and returned to the hospital.

A cost report may be submitted in electronic format with a printed signed page of certification.

(c) Extensions - Cost reports shall be prepared with due diligence and care to prevent the necessity for later submittals of corrected or supplemental information by hospitals. Extensions may be granted only upon approval by Medicaid. The extension request must be in writing, containing the reasons for the request, and must be made prior to the cost report due date. Only one thirty-one day extension per cost reporting year will be granted by the Agency.

(d) Penalties

(1) Late Filing - If a complete uniform cost report is not filed by the due date, the hospital shall be charged a penalty of one hundred dollars per day for each calendar day after the due date. This penalty will not be a reimbursable Medicaid cost. The Commissioner of Medicaid may waive such penalty for good cause shown. Such showing must be made in writing to the Commissioner with supporting documentation. A cost report that is over ninety (90) days late may result in termination of the hospital from the Medicaid program. Further, the entire amount paid to the hospital during the fiscal period with respect to which the report has not been filed will be deemed an overpayment. The hospital will have thirty (30) days to refund the overpayment or submit the cost report after which Medicaid may institute a suit or other action to collect this overpayment amount. No further payment will be made to the hospital until the cost report has been received by Medicaid.

(2) Reporting Negligence

a. Whenever a provider includes a previously disallowed cost on a subsequent year's cost report, if the cost included is

attributable to the same type good or service under substantially the same circumstances as resulted in the previous disallowance, a negligence penalty of up to $10,000 may be assessed at the discretion of the Alabama Medicaid Agency.

b. This penalty shall be in addition to, and shall in no way affect, Medicaid's right to also recover the entire amount of any overpayment caused by the provider's or its representative's negligence.

c. A previously disallowed cost, for the purposes of a negligence penalty assessment, is a cost previously disallowed as the result of a desk review or a field audit of the provider's cost report by Medicaid and such cost has not been reinstated by a voluntary action of Medicaid. The inclusion of such cost on a subsequent cost report by the provider, or its representative, unless the provider is pursuing an administrative or judicial review of such disallowance, will be considered as negligent and subject to the penalty imposed by this Rule.

(4) Calculation of Medicaid Prospective Payment Rates for Inpatient Claims.

(a) Payments for inpatient services shall be based on a prospective per diem rate determined by the Alabama Medicaid Agency.

(b) Rate Setting Period - The as-filed immediately preceding year's cost report will be used to compute a hospital's prospective inpatient per diem rate each year, except for those hospitals on an operating budget or filing an abbreviated cost report, thus the base period is moving. The cost report shall be desk reviewed and any non-reimbursable items will be removed from reported cost prior to calculating a rate.

(c) Rate Review Period - The per diem rates as calculated by Alabama Medicaid Agency shall be provided to the hospitals prior to the effective date for their information and review.

(d) Per Diem Rate Computation - The total Medicaid cost per diems from the cost report shall be adjusted as follows:

(1) The medical education cost per diem and the capital-related cost per diem are subtracted from the inpatient hospital cost per diem. The remaining cost per diem is separated into Administrative and General (A & G) and non-Administrative and General per diem components. The components will then be multiplied by the applicable hospital industry trend factor (as adjusted by any relevant trend factor variance). The resulting trended A & G cost per diem will be arrayed within hospital grouping in ascending order. The number of psychiatric hospitals will be multiplied by 60% to determine the position of the hospital that represents the 60th percentile. That hospital's cost in each urban grouping will become the ceiling for that grouping. The ceiling or actual cost per day (whichever is less) will be the adjusted A & G per diem cost. Add the adjusted (if applicable) A & G per diem component cost to the non-administrative per diem component cost. Psychiatric hospitals shall be subject to a 60th percentile ceiling.

(2) Capital-Related and Medical Education Costs Per Diem:

a. Adjust capital-related cost for all hospitals per diem by any applicable low occupancy cost per day.

b. Medical Education cost per diem will be multiplied by the hospital industry medical education costs trend factor.

(3) The total Medicaid per diem cost per day, subject to the overall 80th percentile ceiling, shall consist of:

a. Operating costs as adjusted in (~~a~~1) above.

b. Capital-related costs as determined in (2)(b) above.

(4) The total cost per day will be arrayed in ascending order. The number of hospitals will be multiplied by the applicable percentile to determine the position of the hospital that represents the appropriate percentile. That hospital's cost will be the ceiling.

(5) The lesser of the above determined ceiling or actual cost per day shall be added to any applicable education cost. The sum shall be a hospital's Medicaid per diem rate for the new period.

(e) Adjustments to Rates - The prospectively determined individual hospital's reimbursement rate may be adjusted as deemed necessary by the Agency. Circumstances which may warrant an adjustment include, but are not limited, to:

(1) A previously submitted and/or settled cost report that is corrected. If an increase or decrease in rate results, any retroactive adjustments shall be applied as of the effective date of the original rate. Any such payment or recoupment shall be made by a rate change and/or a lump sum adjustment if the adjustment applies to the current rate period, or by a lump sum adjustment, if the adjustment applies to a prior rate period.

(2) The information contained in the cost report is found to be intentionally misrepresented. Such adjustment shall be made retroactive to the date of the original rate. This situation may be considered grounds to suspend the hospital from participation in the Alabama Medicaid Program.

(3) The hospital experiences extraordinary circumstances which may include, but are not limited to, an Act of God, war, or civil disturbance. Adjustments to reimbursement rates may be made in these and related circumstances.

(4) Under no circumstances shall adjustments resulting from paragraphs (1) through (3) above exceed the ceiling established. However, if adjustments as specified in (1) through (3) so warrant, Medicaid may recompute ceilings.

(5) Low Occupancy Adjustment - A low occupancy adjustment shall be computed for hospitals which fail to maintain the minimum level of occupancy of the total licensed beds. A 70% occupancy factor will apply to hospitals with 100 or fewer beds. An 80% occupancy factor will apply to hospitals with 101 or more beds. Such adjustment will be composed of the fixed cost associated with the excess unoccupied beds and shall be a reduction to Medicaid inpatient cost. It shall be computed in the manner outlined as follows:

LOW OCCUPANCY ADJUSTMENT FOR HOSPITALS

$$LOA = \left(1 - \frac{TBD}{Y\ ABD}\right) ACC$$

TBD = Total Bed Days Actually Used During the Cost Report Period,

ACC = Allowable Capital Cost

ABD = Available Bed Days Which is Determined by Multiplying the Total Licensed Beds Times the Number of Days in the Cost Report Period

Y = Occupancy Factor (Y = 70% 100 beds or less

(Y = 80% 101 beds or more

Author: Keith Boswell, Director, Provider Audit/Reimbursement.
Statutory Authority: State Plan, Title XIX, Social Security Act, 42 C.F.R. Section 401, et seq.

History: Effective June 9, 1986. **Amended**: Emergency Rule filed and effective September 2, 1010. **Amended**: filed September 20, 2010; effective December 17, 2010.

Rule No. 560-X-23-.06 Disproportionate Share Hospital (DSH) Payments

1) For the period October 1, 2009, through September 30, 2011, Non State Government Owned and Operated Hospitals and State Owned Hospitals which are qualified to, and which do, certify public expenditures claimable for Federal Financial Participation (FFP) in accordance with 42 CFR 433.51(b) will be paid a DSH payment based on the difference between the hospital's reasonable costs incurred in serving Medicaid inpatients, as determined in accordance with Medicare principles outlined in Exhibit C of AL-09-005 Attachment 4.19-A of the Medicaid State Plan, and the interim payments made under paragraph (c)of this Rule.

(2) For the period from October 1, 2009, to September 30, 2011, the Alabama Medicaid Agency shall appropriate and expend the full disproportionate share allotment to hospitals under Section 1923(f)(3) of the Social Security Act (the Act) in a manner consistent with the hospital-specific DSH limits under section 1923(g) of the Act.

(a) Payments to disproportionate share hospitals shall be made to all hospitals qualifying for DSH payments under Section 1923(b) and 1923 (d) of the Act.

(b) Medicaid shall pay qualifying public and state owned disproportionate share hospitals an amount equal to each hospital's allowable uncompensated care cost under the hospital specific DSH limit in Section 1923(g) of the Act during state fiscal year 2007. State owned institutions for mental disease shall receive no more than the same disproportionate share hospital payments the institutions received in state fiscal year 2009.

(c) Qualifying public and state owned disproportionate share hospitals as defined on Exhibit C of AL-09-005 Attachment 4.19-A of the Medicaid State Plan shall receive an amount such that the sum of net inpatient hospital base payments, net outpatient hospital base payments and DSH payments are equal to the greater of 2007 total Medicaid inpatient, outpatient and DSH payments or ninety-five percent of allowable Medicaid costs.

(d) The DSH allotment remaining after DSH payments have been made to public and state owned hospitals shall be paid to private hospitals as defined in Exhibit C of AL-09-005 Attachment 4.19-A of the Medicaid State Plan. DSH payments shall be paid to eligible private hospitals as follows:

(1) A payment equal to 7.93 percent of each hospital's eligible uncompensated care costs in state fiscal year 2007; and

(2) A payment equal to each eligible hospital's pro rata share of the DSH allotment remaining following payment under subsection (a). The payment shall be based upon each hospital's eligible uncompensated care costs under the hospital specific DSH limit in Section 1923(g) of the Act during state fiscal year 2007, divided by the total eligible uncompensated care costs for all eligible private disproportionate share hospitals during state fiscal year 2007.

(e) Total DSH payments to each hospital shall be made during

the first month of the state fiscal year.

Author: Keith Boswell, Director, Provider Audit/Reimbursement.
Statutory Authority: State Plan, Title XIX, Social Security Act, 42 C.F.R. Section 401, et seq.
History: Effective June 9, 1986. **Amended**: Emergency Rule filed and effective September 2, 1010. **Amended**: Filed September 20, 2010; effective December 17, 2010.

Rule No. 560-X-23-.07 Calculation of Medicaid Prospective Payment Inpatient Rate for Out-of-State Hospitals

(1) Payment for inpatient services provided by all out-of-state hospitals shall be the lesser of the submitted covered charges or the Alabama flat rate which shall be composed of the average of the per diem rate paid to out-of-state hospitals in FY 2009 inflated annually by the Global Insight.

Author: Keith Boswell, Director, Provider Audit/Reimbursement.
Statutory Authority: State Plan, Title XIX, Social Security Act, 42 C.F.R. Section 401, et seq.
History: Effective June 9, 1986. **Amended**: Emergency Rule filed and effective September 2, 1010. **Amended:** Filed September 20, 2010; effective December 17, 2010.

Rule No. 560-X-23-.08 Outpatient Services

(1) Outpatient Medicaid Base Payments.

(a) Medicaid shall pay each hospital as a base amount for state fiscal years 2010 and 2011 the total outpatient payments made by Medicaid to each hospital from all sources except DSH payments during state fiscal year 2007, divided by the total outpatient encounters (ICN count) incurred by that hospital in state fiscal year 2007, multiplied by the total outpatient encounters (ICN count) incurred by each hospital during fiscal years 2010 and 2011.

(b) Payment for all out-of-state outpatient hospital services will be from approved rates, by procedure code, as established by Medicaid with any annual/periodic adjustments to the fee schedule being published on the Alabama Medicaid Agency's website (http://www.medicaid.alabama.gov/billing/fee_schedules.aspx?tab=6).

(c) The Medicaid rates were set as of October 1, 2009 and are effective for services on or after that date. Except as otherwise noted in the plan, Medicaid developed fee schedule rates are the same for both governmental and private providers and the fee schedule and any annual/periodic adjustments to the fee schedule are published on the Alabama Medicaid Agency's website (http://www.medicaid.alabama.gov/billing/fee_schedules.aspx?tab=6).

(2) Outpatient Access Payments.
For the period from October 1, 2009, through September 30, 2011, in addition to any other funds paid to hospitals for outpatient hospital services to Medicaid patients, each eligible hospital, except for hospitals as outlined in 3. below, shall receive outpatient hospital access payments each state fiscal year. The outpatient hospital access payment shall be calculated as follows:

(a) The Medicaid Agency shall identify the total Medicaid outpatient hospital payments to privately operated hospitals for state fiscal

year 2007.

(b) The Medicaid Agency shall estimate the amount that would have been paid for the services identified in step (a) using Medicare principles consistent with the upper payment limit (UPL) requirements set forth in 42 CFR 447.321.

(1.) The Agency shall subtract step (a) from step (b) to determine the aggregate outpatient hospital access payment amount.

(2.) Each eligible privately owned or operated hospital, excluding private free-standing psychiatric hospitals, shall annually receive outpatient access payments equal to the difference between the hospital's allowable cost of providing Medicaid outpatient hospital services for state fiscal year 2007 and base payments for the current fiscal year.

(c) Outpatient hospital access payments shall be made on a quarterly basis.

(3) Privately owned acute care hospitals, that meet the criteria in (a) and (b) below, shall be paid an enhanced payment not to exceed in the aggregate, the upper payment limit (UPL) as described in 42 CFR 447.321.

(a) The hospital must be located in a county with a population greater than 200,000 (according to the latest U.S. census), and

(b) The hospital must participate in the county's largest city's outpatient/emergency room assistance program. The enhanced payment to privately owned acute care hospitals, that meet the criteria in (a) and (b) above, excluding hospitals which predominately treat children under the age of 18 years, will be determined on an annual basis by Medicaid and divided evenly among qualified hospitals.

Author: Keith Boswell, Director, Provider Audit/Reimbursement.
Statutory Authority: State Plan, Title XIX, Social Security Act, 42 C.F.R. Section 401, et seq.
History: Effective June 9, 1986. **Amended**: Emergency Rule filed and effective September 2, 1010. **Amended**: Filed September 20, 2010; effective December 17, 2010.

Rule No. 560-X-23-.09 MEDICARE CATASTROPHIC COVERAGE ACT DAY AND COST OUTLIERS

(1) Day Outliers - The Alabama Medicaid Agency does not impose durational limits for medically necessary inpatient services provided to children under the age of 6 years in hospitals deemed by the Agency as disproportionate and under the age of 1 in all hospitals. Because we pay for all medically necessary days of care for these children, we meet the day outlier requirement of the Medicare Catastrophic Coverage Act and no additional payments are available.

(2) Cost Outliers

a. A cost outlier for an extremely costly length of stay for a child under age 6 receiving medically necessary services in a hospital deemed by the Alabama Medicaid Agency as disproportionate share and under age 1 in all hospitals, is defined as a claim for payment for a discharged child for allowable services rendered from the date of admission to the date of discharge which meets the following criteria:

b. The Medicaid allowed charges per day for the length of stay for Medicaid eligible children as outlined above must exceed four times the hospital's mean total charge per day as established by Medicaid from Agency paid claim data.

(c). Payment of Cost Outliers

The sum of allowed charges in excess of four times the mean total charge per day shall be multiplied by the hospital's current rate period percent of total Medicaid cost to total Medicaid charges (per Worksheet C of the Medicaid Cost Report) to establish the amount to be paid as a cost outlier. The outlier payment per Medicaid eligible child as outlined above shall be limited to $10,000 per discharge and a total of $50,000 during the per diem rate cycle October 1 through September 30.

Author: Keith Boswell, Director, Provider Audit/Reimbursement.
Statutory Authority: State Plan, Title XIX, Social Security Act, 42 C.F.R. Section 401, et seq.
History: Effective June 9, 1986. **Amended**: Emergency Rule filed and effective September 2, 1010. **Amended**: Filed September 20, 2010; effective December 17, 2010.

Rule No. 560-X-23-.10 The CMS 2552-96 Cost Report

(1) The Alabama Medicaid Agency uses the electronic cost report (ECR) filing of the Form CMS-2552-96 Hospital and Hospital Health Care Complex Cost Report, as defined in CMS Provider Reimbursement Manual (PRM) 15-II along with all accompanying schedules, forms and supporting information (hereinafter referred to as "Form CMS 2552-96)for its Medicaid program and all acute care hospitals must submit this report for fiscal years ending in 2011.

(2) All Medicaid data completed. The due date corresponds with the Medicare intermediary.

(3) Any extension or change to report period must be reported to the Medicaid Provider Audit Division in writing.

(4) Late Filing - If a complete uniform cost report is not filed by the due date, the hospital shall be charged a penalty of one hundred dollars per day for each calendar day after the due date.

Author: Keith Boswell, Director, Provider Audit/Reimbursement.
Statutory Authority: State Plan, Title XIX, Social Security Act, 42 C.F.R. Section 401, et seq.
History: Effective June 9, 1986. **Amended**: Emergency Rule filed and effective September 2, 1010. **Amended**: Filed September 20, 2010; effective December 17, 2010.

Rule No. 560-X-23-.11 Other Matters

(1) The total Medicaid cost per diems can be adjusted if the hospital experiences extraordinary circumstances which may include, but are not limited to, an Act of God, war, or civil disturbance. Adjustments to reimbursement rates may be made in these and related circumstances at the discretion of the Alabama Medicaid Commissioner.

(2) New Hospital Facilities - A new facility shall submit a budget of cost for Medicaid inpatient services for its initial cost reporting period. The Alabama Medicaid Agency will determine a per diem rate from this budget. After the budget period, an actual cost report will be filed for the budgeted period. The Alabama Medicaid Agency will calculate a per diem rate in order to determine if any under or overpayment has been made to the hospital.

(3) In a transfer which constitutes a change of ownership, the old and new providers shall reach an agreement between themselves concerning trade accounts payable, accounts receivable, and bank deposits. Medicaid will pay the new provider for unpaid claims for services rendered both prior to and after the change of ownership. The new provider shall be liable to Medicaid for unpaid amounts due Medicaid from the old provider.

(4) The hospital must "split bill" for inpatient services each year as of December 31. This "split billing" period is necessary for the hospital and the Alabama Medicaid Agency to determine eligibility for services provided each calendar year.

Author: Keith Boswell, Director, Provider Audit/Reimbursement.
Statutory Authority: State Plan; Title XIX, Social Security Act, 42 C.F.R. Section 401, et seq.
History: Emergency rule filed and effective September 2, 2010. **Amended**: Filed September 20, 2010; effective December 17, 2010.